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FEB 22 2011

emailed validation letter 2/25/11

Application for License to Operate a Long-term Care Facility

For Office Use Only
Received <u>2.22.11</u>
Amount <u>\$170</u>

Ch# 165268

I. IDENTIFICATION

Name dba Bolster Health Care Group, LLC  
Auburn Health Care  
 Address 139 Pearl Street  
 City/County/Zip Auburn Logan 42206  
 Telephone number 270-542-4111 Stephanies@bolster-jeffries.com  
 Administrator Stephanie Semrick  
 Date facility operation began at current address 1963  
 Date facility began operation under current owner March 1, 2002

II. TYPE BEDS

No. beds licensed

No. beds requested

Skilled	<u>0</u>	<u>0</u>
Nursing Home	<u>0</u>	<u>0</u>
Nursing Facility	<u>66</u>	<u>66</u>
Intermediate Care	<u>0</u>	<u>0</u>
ICF/MR	<u>0</u>	<u>0</u>
Personal Care	<u>0</u>	<u>0</u>

II. CONTROL (check one in each column)

State	<u>Profit</u>	<u>Individual</u>
County	<u>Nonprofit</u>	<u>Partnership</u>
City		<u>Corporation</u>
<u>Private</u>		

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Bolster Jeffries Health Care Group  
Nancy and Robert Bolster 101 Clay Cole Rd Elkton, Ky 42220  
Kathryne and William Jeffries 322 Gray Hawk Trail Clarksville, TN 37043

If facility owned or leased by a corporation, complete the following:

Name of corporation N/A  
Address of corporation N/A  
President or Chairman N/A  
Vice President N/A  
Secretary N/A  
Treasurer N/A

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
<u>N/A</u>	<u></u>
<u></u>	<u></u>
<u></u>	<u></u>

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Stephanie Service  
Signature of authorized representative

Administrator  
Title

1/27/2011  
Date

Return Application and fee to:

Office of Inspector General  
275 East Main Street, 5E-A  
Frankfort, Kentucky 40621

OIG 5  
(10/2002)

25% Robert Bolster

25% Nancy Bolster

25% William Jeffries

25% Kathryne Jeffries